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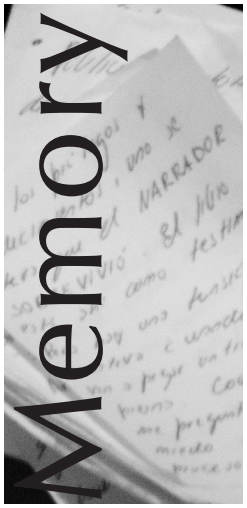

Letter to the president of the College of Medicine

Carta al presidente del Colegio Médico

***Maccacaro**, Giulio Alfredo*[1]

ABSTRACT This text reprints the letter written by Giulio Alfredo Maccacaro (1924-1977) to the president of the College of Medicine in Milan, published in Jean-Claude Polack's *La medicine del capitale* [The medicine of capital]. This reedition more than 40 years later, in the section Memory and History, seeks to recover the figure of Giulio Maccacaro not in his individual path but rather as a person inscribed in a collective movement – along with Giovanni Berlinguer, Franco Basaglia and many others – that rethought the role of medicine and combined scientific practice with a strong social commitment.
KEY WORDS History, 20th Century; Health, Occupational; Health Care Reform; Social Class; Social Inequity; Italy.

RESUMEN Este texto reproduce la carta escrita por Giulio Alfredo Maccacaro (1924-1977) al presidente del Colegio Médico de Milán, publicada en 1972 en el libro *La medicine del capitale* de Jean-Claude Polack. Luego de más de 40 años, esta reedición en la sección Memoria e Historia tiene por objetivo recuperar la figura de Giulio Maccacaro, no como trayectoria individual, sino inscripto en un movimiento colectivo –junto a Giovanni Berlinguer, Franco Basaglia y tantos otros– que replanteó el papel de la medicina y logró conjugar la práctica científica con un fuerte compromiso social.
PALABRAS CLAVES Historia del Siglo XX; Salud de los Trabajadores; Reforma Sanitaria; Clase Social; Inequidad Social; Italia.

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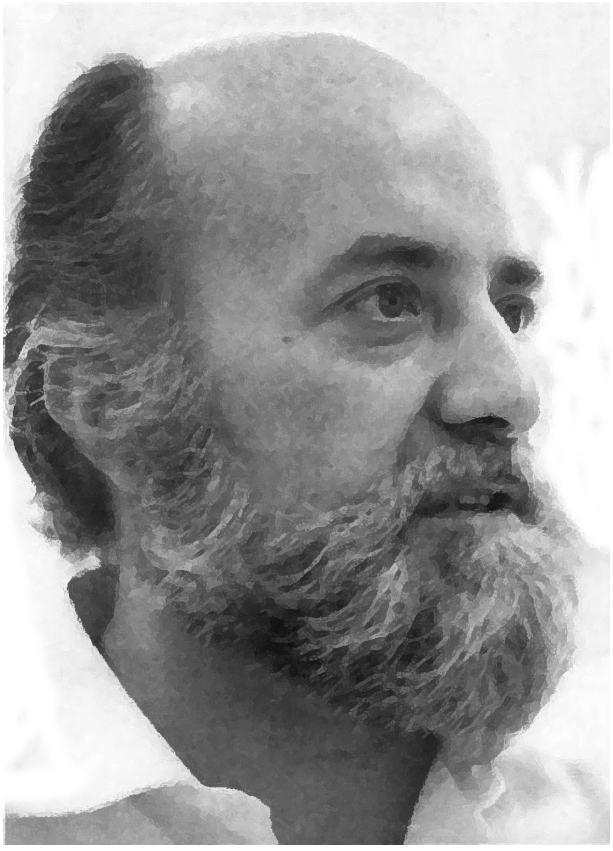
ABOUT GIULIO MACCACARO AND THE ITALIAN PUBLIC HEALTHCARE MOVEMENT



Giulio Alfredo Maccacaro (1924-1977).

Giulio Alfredo Maccacaro (1924-1977) was born in Codogno, Italy. He received his degree in Medicine and Surgery from the Università degli Studi di Parma in 1948 and in the following year he joined the Department of Genetics of the University of Cambridge, of which Ronald Fisher was the director. He returned to Italy as director of the Institute of Medical Statistics and Biometrics at the Universitá degli Studi di Milano, where he introduced the ideas of Ivan Illich, Thomas McKeown, Archibald Cochrane and Richard Doll.

As an editor, he founded the scientific journal *Epidemiología & Prevenzione*, currently published by the Associazione Italiana di Epidemiologia. He was the director of *Sapere*, a journal founded in 1935 which critically addressed topics such as energy and ecological crises, the effects of dioxin in the city of Seveso, demography, information technology and labor organization, industrialized food, genetics, psychiatry, psychology and the relationship among medicine, economy and power. In 1972 he created the collection "Medicine and Power" under the great editor and political activist Giangiacomo Feltrinelli.

Maccacaro's editorial activity was founded on the need to translate what the Italian sanitary movement set as its aim: connecting medicine with strong social commitment. This notion led him to work with Lorenzo Tomatis in different research projects on carcinogens in factories, which gave rise to a new labor legislation in 1970 (Act 300). This research influenced the development of the field of worker health in Latin America, particularly in Argentina with the founding of the Institute of Occupational Medicine [*Instituto de Medicina del Trabajo*] at the Faculty of Medicine of the Universidad de Buenos Aires. Along with Franco Basaglia, Maccacaro was part of the Trieste group, which gave rise to the 1978 Psychiatric Reform (Act 180). He also participated with Giovanni Berlinguer and many others in the Italian Sanitary Reform outlined in Act 833, passed that same year.

The Italian sanitary movement was the result of a vast collective construction that produced, among other things, "*La Mozione de Castellanza*," a document regarding the reality of workers at the Montedison factory of Castellanza. This document was signed by over 600 individual supporters and numerous groups, including: *Psiquiatria Democratica*, *Magistratura Democratica*, *Gruppo Ricercatori M. Negri Milano*, *Gruppo Prevenzione tutela salute di Castellanza, Gruppo Prevenzione e Igiene Pertusella, Collettivo democratico operatori lavoratori ospedalieri Biella, Collettivo assintenza sanitá Montechari, Comitato iniciativa medica democrática Bologna, Collettivo operatori sanitari Bologna, Collettivo studenti in Medicina Milano, Comitato agitazione facoltá di Medicina Pisa, Collettivo Medicina Roma, Collettivo Medicina Firenze, Collettivo femminista di medicina di Firenze, Collettivo femminista 8 marzo di B. Arsizio; Commissione femminile comunista di Rifredi-Firenze, Collettivo Medicina democrática Legnano, Collettivo popolare di Rescaldina, Collettivo político S. Anna B. Arsizio, Collettivo dei delegati spedale di Legnano, Collettivo político di Vicenza, Collettivo unitario di lotta per la salute*

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Vicenza, and Servizio medicina democrática per la salute mentale Trieste. This was the inception of Medicina Democratica: Movimento di Lotta per la Salute and the homonymous journal, the first copy of which was published in April 1976. Both the movement and the journal still remain in full force.

This diversity of groups reflects, on the one hand, the collective commitment in the reformulation of the role of medicine and, on the other, the social construction and the historical context within which the figure of Giulio Maccacaro and the letter we copy below were inscribed.

LETTER TO THE PRESIDENT OF THE COLLEGE OF MEDICINE

Mr. President of the College of Medicine of the province and city of Milan:

Last September 25th, while I was working on the foreword to *La medicina del capitale*, you sent me the following lines:

> Regarding certain matters of your concern, we urge you to present yourself in our offices of the College of Medicine this October 4th at 11:30 AM so as to meet with the president or one of his representatives.

I did not have many doubts about the inquisitional nature of your invitation, but I did not make the mistake of questioning the purpose of the interview. Because, please understand, I am not Josef K, nor even a surveyor: among the paperweights and the ashtrays on your desk I will find neither my guilt nor my salvation. Furthermore – I thought joylessly – never had we thought impossible the sweaty purpose of a hand eager to become a hug of greeting.

Nonetheless, on October 4th I appeared punctually before your somewhat intimidating presence, and I listened to the charges pressed against me with great attentiveness, to which you may attest, and with a cruelty I now confess. You read to me – as if they were accusations – words and phrases from a work of mine, recently presented in Perugia, where I was invited by the Italian Institute of Social Medicine, on the topic "Medical information and participation." And as you were reading, the thickening of the narrow lines of your forehead, the subtle refraction of sweat on your lip, the stuttering in your words and your incidental pauses, moved me in the clarity of their fatigue and uselessness: your capacity for discernment and willingness, evidently impaired, came together in unparalleled success.

I myself strove to recognize – not always successfully – in the echo of that hesitant diction the rather familiar voice of my opinions expressed in a public debate about power and the submission of medicine in capitalist society, about the deformations they produce in medical practice and in the doctor-patient relationship, about the inherent responsibilities and complicities of health information.

I could have helped you understand, Mr. President, but I did not: it would have contaminated the clarity of an exemplary situation. I could have calmed you down a little but I would have deprived you of the arrogance you needed in order to tell me – later on – that you had considered the possibility of imposing disciplinary sanctions on me. Now you see why – by standing up and refusing to reply to protests not ritually formulated, and both for the present and for the future – I left avoiding the tempting trap of conciliation.

My cruelty was, then, not brutal: perhaps it was just a way to hide a concern and an understanding that I did not want you to consider obliging. All I see is the formalization of your investigation.

However, I believe that your initiative goes beyond the irrelevance – please believe it – of both our persons. The research carried out recently and the news collected by others reveal that you are the first president of the College of Medicine – at least during the post-fascist period – who considers himself fit to inquire into the opinions expressed by a doctor, who is also a professor, during a scientific and political debate. And able to do it in the name of and in defense of what is known as "professional dignity," a dignity never sullied or offended by the

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corruption, violence, servility and perversion of some of its members, but by the diagnosis of these evils and the investigation of their causes.

This diagnosis and this investigation, which deeply penetrate the social and political framework in which medicine is expressed as a system, are the roots that gave birth to Jean-Claude Polack's book. You interrupted me just when I was writing a foreword to that book: the impertinence that Count La Fère severely punished behind the Honorable Grimaud's back. But do not fear; this is not my point. I had thought, after resuming my writing, about continuing the text where it had been left off, going back to the page where I had stopped. But I could not: between the book and me, the disturbing memory of your arrogance had uncomfortably imposed itself.

The foreword I had begun, Mr. President, and that will be kept in a drawer, did not assume your existence. It imagined readers to whom you are irrelevant, it was to make references inaccessible to you, it implied commitments that would not be generous to ask of you.

I wanted to present Polack's book by giving it a cultural context, by proposing a reading guide and suggesting criteria for its use. This is the purpose of forewords, particularly if the texts are difficult.

And indeed *La medicina del capitale* is not always easy. This is because of the effort – which has a great deal of predecessors but none quite like the book itself – to turn upside down, in a coherent analysis that uses the instruments of structuralism based in a Marxist methodology, the multiplicity of the medical system. Because of the density of phrase – always notable, sometimes heavy, often fermentative – whose expressed and alluded meanings never seem to be able to be fully captured. Because of its extraordinarily generous and compelling insights, some of which are surprising, and of its propositions, some of which are tempting, for future analyses and studies.

From a certain perspective, then, Polack's book is a long and extraordinary foreword to just that: invitation and indication, index and summary, stimulus and warning. It is especially agreeable in parts, no less so and maybe better than as a whole, for a study, a seminar, an investigation or a work plan in which it is desirable to receive the contribution of many so as to achieve a political intelligence increasingly able to penetrate and transform medicine.

The foreword to a foreword: this, Mr. President, is what a small page would have turned into if it had not been for your disagreeable – but very instinctive! – intervention. A task that, in my immodesty, I had suspected would be futile.

However, now, after having met you, I am sure that even the preface to a title may be useful.

Mr. President, children who are today born in countries with elevated industrial development have a life expectancy of about seventy years. However, from the Greco-Roman time up to the 18th century, life expectancy did not exceed thirty years. This same difference persists today among the children born in our countries and those children born in underdeveloped countries. Therefore, it has been verified, in time and space, that the industrial transformation increased life expectancy. This kind of information is constantly spread, also reaching the educational field. Everybody knows it and it is likely you do too. What is not taught or spread, and consequently is unknown, is that until the beginning of the industrial revolution, the average life expectancy was the same for everybody no matter the social class to which people belonged. After the industrial revolution, death and disease learned to discriminate, increasingly emphatically and severely, within a community: between the rich and the poor, between the capitalist class and the working class. This thesis has been demonstrated in numerous research studies (a) whose relevance rarely escapes the closed community of scientists and specialists. People live, fall ill and die according to their social class, just like the people who died tragically on the Titanic's deck (b). Naturally, Mr. President, we here recall the terrible end of the unsinkable liner as a metaphor that, nevertheless, can be perfectly applied to all societies organized by a class system.

Another good example, among many possible ones, and probably the first presented as a scientific research study in a journal as responsible as the *American Journal of Public Health* (4) could be the information provided in Table 1, describing the mortality rate based on the incomes in Providence, Rhode Island, in 1865.

The figures speak for themselves but, in case you were reluctant to understand them, I would also like to mention the dramatic difference

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between the general mortality rate of taxpayers (10.8 deaths per 1,000 individuals) and non taxpayers (24.8 deaths per 1,000 individuals), the atrociously significant difference between both groups in the age of highest work performance, between 30 and 59 years of age, showing 10.36 "non taxpaying" deaths against 1.4 "taxpaying" deaths between 40 and 49 years of age.

Providence is simply one city among many in the United States. I agree, but I could quote current and comparable data obtained by Rowntree (5) for the city of York in England; by Collins (6) for Copenhagen, in Denmark; and by other authors (1) for other cities and other countries: all of them tell the same true story that repeats itself decade after decade and is worse in the last ones.

The year 1865 is just one year among many others in the past century, but I would like to remind you that in that year Bismarck and Napoleon III met in Biarritz, Lincoln was killed in Washington, Proudhon published *The political capacity of the working class*. In that same year the following breakthroughs took place: in England, the electrolytic refining of copper; in Germany, the Siemens-Martin process for the production of steel; and in France, the manufacture of the first repeating rifle. It was in that very year, while Claude Bernard's work *An Introduction to the Study of Experimental Medicine* appeared and gained fame, that Pasteur initiated his research on the microbial origin of diseases and Mendel reported his first observations on the inheritance of biological features: the bases for genetic determination, infectious transmission and biochemical pathogenesis were set forth as germinal ideas (and later as *idolatry*) of modern and scientific medicine.

Naturally, the fabric of politics, science and medicine appeared to be incidental, but the more analytic and critical interpretation of parallel chronologies would show the need for and the plan of this fabric that could be defined, therefore, as historical.

Nonetheless, Mr. President, you would not make this same interpretation, which I admit, is too demanding. As demanding as this book, whose title I seek to make at least understandable to you. So then...

So then, to speak of *capitalist medicine* is to provide more than a historic or sociological indication; it is to provide the result of a political analysis according to which the direction of capital, in the societies where it has supreme power, feels obliged to affirm itself and, in order to control its contradictions, to assume total management of the medical system in all its areas and relationships. In such societies, medicine in any of its fields, whether scientific or care-based, in the private or in the public sphere, in university classrooms and in hospital rooms, always belongs to capital, in the sense that it is functional to its needs of preservation and development, even through the forms and realities of the act of care.

The societies we refer to are those that were born of bourgeois revolutions; nobody would think of denying the bourgeoisie – with its anti-obscurantism and antiauthoritarian challenge, its determination in achieving the triumph of reason and democracy – the importance of its historical role that at the time was authentically revolutionary, although only partially liberating.

This first contradiction – should I ask for permission to say something so elementary? – arose from the fact that the bourgeoisie, after becoming aware of itself as a social class, subjectively affirmed that social redemption which it objectively denied without mercy.

None of its inventions were more important than the capitalist system: evidently founded

Table 1. Mortality rate per 1,000. Providence, Rhode Island, 1865.

Ages	Taxpayers	Non Taxpayers	"Non taxpaing" deaths for every "taxpaying" death*
0-1	93.4	189.8	2.03
1-4	40.3	66.6	1.65
5-9	15.9	15.7	0.99
10-19	3.0	8.2	2.73
20-29	6.0	11.8	1.97
30-39	4.5	15.5	3.44
40-49	1.4	14.5	10.36
50-59	8.6	25.1	2.92
60-69	15.1	39.5	2.62
70-more	32.9	138.5	4.21
All ages	10.8	24.8	2.30

Source: Charles V. Chapin (4 p.648).

*Calculated according to the net numerical difference between the population of "non taxpayers" (44,080) and the population of "taxpayers" (10,515).

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on the social production and the private appropriation of goods as a necessary condition for the reproduction and increase of capital through the expropriation of the surplus value that the capitalist – who is allowed to retain the benefit – exacts from the workers who must necessarily sell him their workforce; it is in this way that the latter become the historical antagonists of the former and their history the story of their struggles.

It is clear then, though in a very simplified way, that capitalism is interested in consuming and conserving the availability of the workforce, that is, keeping it as long as it has to use it in such a way and to such an extent as to make the most of it, optimizing the difference between the cost of conservation and the benefit of consumption. Medicine is asked to help resolve, within the scientific rationality, this new and fundamental contradiction. The capitalist system must assume the management of all the areas of medicine; this means the management of the doctor as well as the patient, of the disease as well as of the institution, of training as well as of the profession, of the production of drugs as well as their demand, and so on.

Medical science becomes scientific when power becomes bourgeois. The new leading class did not use and would not have been able to use the science of the power that it had insisted on destroying – no science, neither current nor past, has alternatives different from those of the power that has determined it – but rather founded and developed for itself a new science and a new medicine, considered scientific.

The bourgeoisie, marching towards the conquest of nature and the exploitation of man, the latter being necessary for the former and both being necessary for the accumulation of capital, confirms a new intelligence of disease, removing it from astral influences, exorcizing it of diabolic invasions and finally ripping it from the metaphysics of evil. For man's workforce to be the essential and adjustable flow that replenishes variable capital, it is necessary for both disease and health to be analyzed by a scientific reason that categorically affirms its physical naturalness, assures its reduction to controllable facts and establishes discipline by formulating laws.

The new enlightened medicine grants all thought, not only scientific thought (c), of all subsequent decades until our days, two extremely productive and useful models: man as a particular case of nature and nature as general antagonist of man.

The contradiction contemplated in the dual need for both models is resolved according to Darwin's theory of competition as the economic law of nature and as the natural law of economy.

From the first model will emerge, as a *medical subspecies*, that objectification of man that is the logical and practical need of its scientific use (apparently a human use of science), ordinary and consistent from the places of production to the medical experimentation room (7).

With respect to the second model, any casual allocation – the disease that focuses on the individual due to the harmful socio-physical environment that surrounds him and which is in turn oppressed by the impositions of the productive system – is centrifuged out of the system itself, towards a nature "far out there" where the dark enemies of health nest and thrive, and can only be exterminated by science; that science, it is understood.

Malaria ceases to be the consequence of a secular unhealthiness to become the result of *Plasmodium* infection though Anopheles mosquitos; pulmonary tuberculosis is no longer the result of economic deprivation and longing but of *Mycobacterium tuberculosis*; a heart attack is no longer the result of painful emotions but of atheromatous obstruction of a coronary artery. This is also valid for other numerous other truths, which are also infinitely reducible.

With this truth the new science is illuminated and the new medicine is built. They launch their victorious challenge not only against infectious viruses, epidemic plagues, the scourge of deprivation, but also against the pathology that is natural disorder – disastrous and unpredictable, irrational and uncontrollable – a hidden and lingering threat to each capitalist project that needs the work of man: that is, to its possibility of existence and its ability to produce, but above all to the programming of its existence to produce.

This is the goal and the limit of capitalist medical science, which was born from a class out of its will for hegemony and from a system in need of development. To acknowledge this – do you follow my reasoning, Mr. President? – does not

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mean failing to recognize the statistical objectivity of this science's success, the possible uses of its signifiers. On the contrary, it means understanding correctly its genesis and its development, its hypothesis and its determination, its logic and its contradiction, in order to finally come to understand the crisis.

This is the interpretation, with sustained tenacity, of Polack's book. The following lines are dedicated to a concise certification of this crisis. Mr. President:

> Large numbers of the world's people, perhaps more than half, have no access to health care at all, and for many of the rest, the care they receive does not answer the problems they have. The grim irony is that dazzling advances in biomedical science are scarcely felt in areas where the need is greatest. Vast numbers of people are dying of preventable and curable diseases, or surviving with physical and intellectual impairment for lack of even the simplest measures of modern medicine.

These words do not belong to me and therefore they are not under your scrutiny, but I hope they are worth your consideration since they are authored by an American scholar from the Rockefeller Foundation (8). Instead, we owe the following words – but it is only a form of expression, you know, for those who do not live in the perpetual absolution of each cultural debt – we owe them, as I said, to a well-known professor in Harvard (Massachusetts):

> Medical science has learned how to change the course of the natural history of disease, to alleviate suffering, to terminate severe illness, to prevent crippling, and to postpone untimely death [...] Wonder drugs like penicillin now provide immediate cure for diseases such as lobar pneumonia, which two decades ago claimed one quarter of its victims. As a result, there has been a decrease in infant mortality and a concomitant increase in life expectancy. Many individuals have been spared the great burden of such chronic diseases as tuberculosis. Many major fatal diseases such as whooping cough, poliomyelitis, diphtheria and typhoid fever have been prevented. But, as I will show, there has been for almost two decades a steady leveling off of our health progress. Curiously this change in trend has coincided with an enormous expansion in our national medical research program. This enormous expansion, along with the deterioration of the healthcare field, constitutes the paradox of modern medicine. (9)

Similarly, one of the most distinguished medical scholars at the University of London and in the United Kingdom puts forward these alarming reflections: (10 p. 821):

> If, for the next twenty years no further research were to be carried out, if there were a moratorium on research, the application of what is already known, of what has already been discovered, would result in widespread improvement in world health [...] As chairman of the Advisory Committee on Medical Research of the World Health Organization, I look forward to the great advances in knowledge that lie around the corner, but I do sometimes wonder whether the vast sums of money now being spent, in many countries, on research might not produce more rapid and spectacular improvement in world health if devoted to the application of what is already known.

It is evident how, on the one hand, the inability of medical science to accept any kind of signifier, or at least an effective one (Bryant), and on the other hand, its persistence despite its asymptotic impotence in authenticating itself as health research to the same minority that hegemonizes it (Rutstein), coalesce to call into doubt, *for the first time and from within the very field, t*he very sense of its continuity. Can you imagine, Mr. President, a more explicit declaration of such a deep crisis? I cannot.

I believe that this crisis, based on the premises that we have somewhat inadequately formulated, is not only plausible but predictable. We have seen that scientific medicine, like all short-range science, has been the expression of the bourgeoisie given the need of capital, carried out in the name of progress. However,

> Thus all the progress of civilization, or in other words every increase in powers of

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> social production [...] such as results from science [...] enriches not the worker but rather capital; hence it only magnifies again the power dominating over labor; increases only the productive power of capital [...] Capital itself is the moving contradiction [...] On the one side, then, it calls to life all the powers of science and nature, as of social combination and of social intercourse [...] On the other side, it wants to use labor time as the measuring rod for the giant social forces thereby created, and to confine them within the limits required to maintain the already created value as value. (11 p. 593)

More trivially, if you will excuse me, we could say that capital has tried to mask its insurmountable contradiction with labor – that is, the need to exploit man, pursued with all the scientific and technical resources available – by affirming itself and to a large degree asserting its dominion over nature, wanting man objectively assimilated through the health that it was able to alienate and subjectively opposed to the health that it was able to claim for itself.

This outline does not tell the entire story but pinpoints the general trends, which are in fact easily recognizable within the development of the academic disciplines and medical education programs. They could only so much as to end in crisis as soon as they crashed – as has happened presently – into two new realities born from the depths of this contradiction. The first has to do with recognizing the political growth of the working class. It is true that the working class

> ...would not be able to resist the weight of the struggle upon itself if it were not for the objectives it sets for itself with an explicit class characterization [in such a way that] whatever the objective of the productive force (and particularly that of science) it cannot act as the explicit aim of the working class struggle except inasmuch as it is immediately traversed by the fundamental directives of the contradiction of class. (12 p. 285)

Nonetheless, it is also true that one of the most readily identifiable "scientific objectives" of worker subjectivity today is effectively traversed by this directive and the production of "medical science" itself, not only due to the flagrancy of its rationalizing role in the capitalist management of social health, but also because in the defense of health, the working class has recognized a totalizing and decisive moment in its class struggle.

The second reality is the one that arises from the core of medicine itself. The struggle against infectious diseases and in a wider sense, physiogenic diseases – necessary for a controllable management of the reserve and reproduction of the workforce, but still used, as was said before, as a pathogenetic envelopment of the franchise granted to the harmful nature of production – has determined the recession: the where, when and how of this will be further developed.

For now it is enough to clarify that the disappearance of a disease considered an expression of the "man-nature contradiction" has revealed, in the sense that it has conferred to it epidemiological relevance, degenerative and substantially anthropogenic disease that, in turn, is an expression of that "man-man contradiction" from whence the fortune of capitalism is born and without which it could not survive.

Now, if having gone through the mythography of germs and genes, of toxins and viruses as observable epiphenomenal symptoms of an inscrutable and irresponsible misadventure, "medical science" could only proclaim itself and live in favor of man, in the name of the immaculate conception of progressive good; starting from the moment in which the overwhelming pathological reality is imposed, arising from organization of labor, from the expropriation of "living time," from the impoverishment of coexistence, from the alienation of the body, from social decomposition, from urban crowding, from environmental pillaging; in short, from everything that is a way, an act and a product of the exploitation of man by man, "medical science" itself is obliged to proclaim itself and express itself *in favor of some men*. Neutrality and illusion are no longer granted to it, and consequently, neither is innocence. It shall either suffer eternal condemnation with capitalism or it shall save itself with work

This is the sense of the crisis, which, if expressed in terms of the imputation of the system, could ferment in its protagonists in the shape of awareness, provided that it is not morally

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discouraged but politically enriched: this, Mr. President of the Physicians, undoubtedly better ones, means acknowledging and choosing one's own class position.

Mr. President, I have tried only to make a title understandable to you, suggesting that this medicine is truly of the capital, both in its genesis and in its crisis. I have based my argument on scientific medicine in the sense of "medical science," less frequently obtained or more easily acquitted of such accusations. Now I request what may remain of your attention, to briefly focus it on – as is to be expected from a letter that cannot bear the commitment of an analysis, much less an outline – other aspects of the medical system, in the way that they are determined, between that genesis and this crisis, by the power of capitalism.

Therefore, because systematicity is denied to us (but only on this epistolary occasion) and because I want to show you the classism of the diseases that affect man here and now, as I will do below, in a stage of the development of capital and of its medicine, and because I have no wish to fall into the traps of conciliation I initially rejected, I shall proceed – if you will allow me – in a concentric way from the great horizon of the planet to something a little more limited within the area of your jurisdiction.

I had told you that the great infectious and parasitic diseases had already been eradicated and that is true: but it is only true for some countries of the world and within their borders, not always in every area and sometimes, within those areas, not for the entire population. For lack of space, I can only provide one example: I choose malaria, not for being the most dramatic case, but because it is clear and well-documented (13,14).

Of the 2.736 million human beings that existed on Earth by the end of 1968, almost two thirds, that is, 1.733 million lived in malaria-infected areas. Of these 1.733 million, only 651 – little more than a third! – lived in zones where malaria had been eradicated. This explains the reason why it is possible, though it may be repulsive, that a disease that has been known for such a long period of time and against which there is an entire system for prevention and treatment, had been yearly contracted during the 1960s by between 100 and 250 million people with a mortality rate of 1 to 2 million a year. Now, if we do not only analyze how many deaths there were or when they occurred, but how and where they took place, we will be able to see with topographic clarity, that the colonialist countries have rid themselves of malaria and have left it to the countries exploited and bled dry by them.

No, Mr. President, do not tell me that this explanation is biased. I mention Belgium and the Congo as testimonies of this truth. The long and cruel agony inflicted on the Congolese by Belgium because of its thirst for wealth is known worldwide. Is it also known that malaria is still an endemic disease throughout the territory of the Congo, while in Belgium it is unknown. You shall undoubtedly refute by arguing that it is not the Belgians' fault that their country is located in northern Europe and that the Congo is in subtropical Africa. On the contrary, it is the Belgians' fault, that is, the colonialist capital of Brussels and its surroundings, since they first showed that malaria could be eradicated *also in the Congo, regardless of latitude* and then they limited that intention to circumscribed areas with inhabitants of the white race! Have you noticed how the scalpel of capitalism with a surgeon's steady hand separates the flesh of humankind, selecting those who can die and those who are allowed to be saved, in order to provide its services and riches? Have you also noticed that on a continental scale, the crisis of medicine becomes increasingly intense? For the last five years the world struggle against malaria has had no more successes; on the contrary, in the countries where the malarial zones dried out and where exploitation, misery and extreme poverty survive, the endemic foci have reemerged. This is the comment of one of the most prestigious English medical journals:

> Although resolute application of existing knowledge could greatly narrow the health gap, the example of malaria shows how hard it is to make full use of available techniques in environmental and social conditions below certain levels of development. (15 p.598)

It is clear, then, that when the countries of capitalist imperialism and their charitable organizations send loads of specialists and vessels full of medicines to the countries where they still impose regimes and governments that support their docile exploitation, they know perfectly well that the first

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action works only to conceal the second. This is why they do it and this is why the doctors who take part in these activities must choose between contradicting themselves and contradicting the system, which means they must face the crisis.

I have already told you, Mr. President, that malaria is nothing but one example of the truth, among many other possible examples; a truth that is still as valid today as it was a century ago: capitalist medicine manipulates diseases according to its own interests, making those diseases fall, based on statistics at an international scale, from the countries that hold imperialist power to those that suffer from it. The same happens within countries: from the dominant classes to the dominated ones.

If you still have any doubt, read carefully the paragraph I transcribe below from the Second Declaration of Havana (February 4th 1962): On this continent of almost 200 million human beings, two thirds are Indians, mestizos and blacks – the "discriminated."

> On this continent of semi-colonies, about 4 people per minute die of hunger, curable illness or premature old age; 5,500 per day, about 2 million per year, 10 million every five years. These deaths could easily be avoided, but nevertheless they take place. Two-thirds of the Latin American population live briefly and live under the constant threat of death. A holocaust of lives, which in 15 years has caused twice the number of deaths of Word War I, still rages. Meanwhile, from Latin America a continuous torrent of money flows to the United States: some 4,000 dollars a minute, 5 million a day, 2 billion a year, 10 billion every five years. For every thousand dollars that leaves us, one corpse remains. A thousand dollars per corpse: that is the price of what is called imperialism! A thousand dollars per death, four deaths per minute!

Unfortunately, when the horror of this type of system was excised from the island of Cuba, the day of liberation from the capitalist colonialism that oppressed both man and doctor, stripping the former of his life and the latter of his role, that day "in Cuba were little more than 50% of the county's doctors, all the rest had fled with the wealthy, the speculators and the oppressors, leaving the people on their own with their diseases" (16), in order to disembark on the shores of capitalism. Perhaps this will also help you, Mr. President, to understand the title of this book.

Nevertheless, it may be more useful to you to leave aside this global scourge: malaria and the health system plight of an underdeveloped continent such as South America, in order to better focus on the diseases of developed and prosperous countries that have known industrial development, the bourgeois revolution and the triumph of capital.

This is the point in which I find myself at a loss. I should, and would like to, review with you the range of relevant diseases in the countries I have listed and in our country, so as to show you statistically and critically – this is, considering the rules and interpreting the exceptions – how from voice to voice, from noxa to noxa, from disease to disease, the agonizing evidence of the social gradient calls out, to show you the severity with which the weight of disease falls upon the subordinate classes, which is the authentic expression of the appraisal conducted by the dominant classes: a cross-transfusion that is still dreadful although it collaborates with the whole medical system.

My difficulty, obviously, resides in the breadth of that range of diseases and the wealth of those statistics that I would like to show you and illustrate for you if I could summarize here the contents of the library of the institute I have the honor of serving, and now, in order to comply with your commitment as a scholar. Therefore, I shall limit myself to drawing your attention to the two opposite ends of that range, that is, to mental disorders on the physical end and to cancer on the somatic end of a disease that, in fact, is always a psychosomatic illness.

With regard to the former, I naturally refer to the very famous but not the only investigation on the relationship existing between social classes and mental disorders (3 p.205) from which I have copied, for your convenience, a small but revealing table (Figure 2). The authors' comment is the following:

> Looking at the percentages, we notice that Class I (which is the privileged one, socially and economically) has a number of patients

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> equal to a third of what would be expected if the ratio between the patients of Class I and the population of the mentally ill were equal to the ratio between individuals of Class I and the general population. Classes II, III and IV also show lower percentages in the column referring to patients. However, the percentage of Class V patients (the less favored class in terms of socioeconomic status) is more than double the percentage of Class V individuals with respect to the whole population. These figures show that our hypothesis, according to which belonging to a certain social class is a conditioning factor for the existence of psychiatric patients, is based on facts. (3 p.206)

Later and more detailed analyses that have considered factors such as age, gender, race, religion and marital status have shown, even more clearly "that the larger or smaller number of cured mental disorders is strongly related to social class" (3 p.215).

With regard to cancer, Mr. President, I suggest that you read a book titled *Statistical studies in aetiology of malignant neoplasm* (17) that has an enormous wealth of data and analyses that are consulted by scholars all over the world. In the first volume, consisting of more than five hundred pages, through its more than forty chapters different varieties and locations of tumors are described: from cancer of the lips, lungs, larynx, intestine, stomach and uterus, and so on. On page 64, in relation to tumors of the first tract of the digestive system (lips, tongue, pharynx and larynx) we find this short phrase as the comment of a table full of data: "it is evident that cancer of these studied areas is more frequent in the poorest classes than in the wealthiest ones." Now, Mr. President, we find this phrase again, with rare exceptions, throughout the whole volume, chapter after chapter, from body part to body part, from tumor to tumor, as a frequent outcry, which despite the asepsis of the scientific language is no less bitter and resounding. Just like the mournful bell tolls that rang out 16 times without being heard from the bell tower of Cirié (18) announcing the death of one more worker from bladder cancer caused by the analytical dyes used to increase the capital of an industry in Piedmont.

Table 2. Social class (from I to V) and distribution of patients and non-patients (psychiatric patients) in the population.

Social class	Patients	Non-patients
I	1.0	3.0
II	7.0	8.4
III	13.7	20.4
IV	40.1	49.8
V	38.2	18.4
	100.0	100.0

Source: Hollingshead AB, Redlich FC (3 p. 205).

I have told you, Mr. President, that from the whole range of diseases I have highlighted the two extremes: do not tell me that between them class discrimination is annulled or reversed. Oh, you do say that. You want to direct my attention to cardiovascular diseases, to the heart attacks of leaders, to the president's atherosclerotic thrombosis. I admit it *et pour cause*. Based on my own calculations, the chances of dying in the sinking of your own yacht are of 1.73 million times greater for the owner of a medium-sized industry than for his own worker. From this point of view, I admit that the working class has incomparably better odds than the capitalist class. However, at the same time I would like to tell you about the existence of studies on cardiovascular diseases that dismiss Osler's thesis of 1910 and that of other scientists of his times that affirmed that several heart and blood vessel diseases are a sad prerogative of the classes privileged by money. The most recent study I know on the topic and which critically analyzes many others reaches the following conclusion:

> Whether the reference is to cardiovascular diseases, diseases of the circulatory system, diseases of the heart, arteriosclerotic and degenerative heart disease, or coronary heart disease, the evidence does not warrant the generalization so widely held from Osler. (19)

On a future occasion, if there happens to be one, I will explain to you, although it may not be true, why Osler's theory makes no sense. The truth is that the person who dies before becoming old has less possibilities of contracting senile diseases.

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For this purpose and restricting our geographical area to national orders, I want to mention this paragraph taken from Berlinguer's research (20 p.32). He writes:

> Although economically underdeveloped regions have higher infant mortality rates, this trend is reversed during the working ages, and life expectancy decreases in relation to industrialization. There are more deaths among workers. What is most significant is the increase in work-related accidents and "occupational diseases" which are legally recognized, but which account only for a part of work-related pathologies. During the twenty years between 1946 and 1966, in Italy there were 22,860,964 confirmed accidents and occupational diseases which resulted in 82,557 deaths and 966,880 people disabled – almost a million people disabled, that is, double the number of individuals disabled in Italy after the two World Wars, which was close to half a million. Accidents and occupational diseases between 1946 and 1966 barely exceeded 1 million per year; however, during the period between 1967 and 1969 this amount increased to 1.5 million per year. Moreover, in 1970 the number of cases rose to 1,650,000. During these years, industrial employment did not increase, therefore these numbers clearly show an increase in factory exploitation and the decreased possibility of renewing the wasted work capacity.

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Mr. President, for your analysis I am going to include this local piece of information, which is part of the national statistics that have not been questioned (d). Turin is probably the Italian city that has been most infiltrated and seized by monopolizing capital. On average, there are 30 occupational accidents every day which result in *anatomical losses* such as a phalange, a finger, a hand... (e).

Now then, if you can imagine and bear this bloody and painful image for a moment, you will have a first and basic approach of what is known as "appropriation of the body by capital." These accidents happen so frequently that they become a specific feature of a certain kind of production activity.

Do I need to tell you that such appropriation, which is not only limited to the body and does not happen only in the factories, stretches its tentacles a little more every day, reaching all places, all moments and all forms of individual and collective life? Furthermore, do you need me to repeat that disease is not the absolute property of capital when it is clear that all capital is and will be pathogenic wherever its scope and implementation may reach? (f).

As we have seen, control and exaction are able not only to produce disease, but also to invent it, always to capital's own benefit, as well as to repress and deny it. Because control and exaction express themselves through a system that is based on the uniformity of the product and the conformity of the producers. The more they are demanded due to the needs of their planning – in order to survive to the contradictions that threaten them – the more they restrict the limits of their tolerance. Basaglia expresses it better than I:

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> ...At different levels of economic development, different degrees of tolerance in addressing a disease can be seen, which coincides with the different definitions of disease that acquire a status of absolute objectivity when formulated by technical experts. (22)

This holds true for both somatic and mental diseases, which are mentioned in the quoted excerpt. In contrast, it is true for the definition of mental and somatic normality whose threshold is continuously changed by capital in accordance with the amount of deviation that can be managed (or rejected) to ensure profit.

To make it clear, Mr. President, without being presumptuous, I would like to be precise about the obvious: the profit of capital includes the dimensions of time and money, and they become the coordinates with which to judge whether it is "worthwhile" to restore normality and whether it is "worth the effort" to assure conformity.

This is the selection test by which the passport to the kingdom of "disease" is handed over to those illnesses that have greater and more immediate margins of recovery of the labor force (acute, specific, "symptomatic," or traumatic diseases, among others) and it is denied to many other diseases (chronic diseases, physical disabilities, mental disorders, etc.) which are defined as "states" or "types" and are forced to wear the uniform of unredeemable exclusion by medical praxis and institutions.

Sometimes, Mr. President, such exclusion is produced of its own accord and receives medical attention, albeit posthumously. At this time I am reading the works of two colleagues, Professor Virginio Porta and Dr. Giorgio Calderini, (23) from the neuropsychiatric section at the Ca'Granda hospital. Their socio-medical research study about suicide attempts in our city is preceded by some comments, from which I have chosen the following:

> In some ways, Milan is at the forefront of Italian economic and socio-cultural progress [...] The period in which our research study was conducted was considered that of greatest economic expansion of what is known as the industrial boom...

That is, the period in which the industrial capital from the north of Italy had drained, due to its need of labor force, a great migratory wave from the south; however, the proper conditions for their settlement had not been prepared in advance, except for jobs related to construction work or machinery operation. The relationship between suicide and migration has been precisely one of the problems studied by Porta and Calderini. I transcribe their words:

> ...Regarding immigration [...] the first period after arriving in Milan is that which most easily leads immigrants to depression and even protest, the two greatest instigators of suicide attempts [...]. In accordance with this information, a year after their arrival to Milan, one out of every 90 immigrant women and one out of every 200 immigrant men will have attempted suicide [...]. Southern women are characterized by their low socio-cultural level: they are frequently illiterate; they live in places inappropriate for habitation, such as warehouses, basements, and so on; their residence in Milan has been short and they are unemployed or perform unspecialized tasks [...]. This seems to be the group most affected by the immigration trauma, a symbol of frustration and economic, social and cultural maladjustment [...]. We should add that southern women do not consider alcohol a solution to their frustrations; on the contrary, it is a solution for men, although they employ it quite moderately. (23 p.221, 254)

I come to a halt at the horror of this situation, Mr. President. I'll say more, within the context of this letter, about the pathology of capital, about the process of getting ill and dying in a specific social class. This letter does not have any sense or purpose if this is not enough for you, if you have not yet understood.

I would like you to be a southern farmer who survived infant mortality in his homeland and came to the north only to lose several years of his adult life as a manual laborer. A man who has learned that some diseases are for his children but never for his employers' children. A man who has lost his fingers under a press or has contracted bladder cancer. A man who is forced to listen every day to

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his neighbor's cough caused by silicosis, or to see a man wincing from the pain caused by an ulcer...

A man like this one, if he is not alcoholic and his wife has not jumped out of a window, will be able to explain to you, much better than I do, Mr. President, how *capitalist medicine manages man's illnesses to its own benefit*.

Naturally, capitalist medicine could not manage diseases if it did not also manage *the patient*, *the doctor* and their mutual *relationship* in accordance with a consistent class logic.

I am going to talk briefly about the most virulent and evident form of such management that appears in every newspaper and weekly magazine, since we both live in this environment and we know it equally well, even though we may have different opinions about it.

In the center of this proud city, an irritating representation is daily renewed and topographically limited (but not only) by four streets that establish its perimeter: the Milan Polyclinic. The institution is considered a "public shame" (24) due to its decay, squalor and overcrowding. Near this "hospital" for the poor, with or without the support of mutual aid organizations, are nestled closely like "a golden crown" numerous clean and comfortable nursing homes and private clinics, which offer excellent medical care to wealthy people. These two concentric health worlds, which in reality are extremely far removed from one another, seem to be only separated by the distance of two streets. In fact they have nothing in common: while the patients' privacy is protected in some places, it is denied in others; the family visits are open in some places and restricted in others; the atmosphere is cozy and well-decorated in some places and barren in others; staff availability is abundant in some places, but it is scarce in others; medical attention ad *personam* is a well remunerated job for some and an exceptional and admired virtue for others.

However, Mr. President, I want you to pay close attention to other issues too – because all of them are significant and each of them is unbearable – so as to look for the most authentic message of the surprising, almost didactic representation of class discrimination among men, who could at least be made equals by suffering the same disease; and consequently, to feel the deep and powerful meaning of this paradoxical nearness – bothersome or mendicant? – that the medicine of the wealthy imposes and accumulates around the medicine of the poor.

This paradox leads us to another one and with this the dilemma is resolved: these two worlds do not have a common base but share the summit. These dissonant universes have a sole orchestra conductor. That short but infinite distance is daily trodden by one person: the infamous clinical doctor.

And it is he, academically and socially recognized as the greatest authority in diagnosis and therapeutic power, it is he who manages to reaffirm control in the ubiquity of the presence of *ubi Petrus ibi Ecclesia*, and also of capitalism, Mr. President.

But do not read into what I am saying. Neither I nor this modest effort really care about the venal dimension of the matter. Profits are not important; what is important is the *clinical doctor's role*. It is necessary to highlight that he is required by the medical world of the dominant class because of his supposed doctrine and practice, his knowledge and experience, which, I must say again, he has learned from another world: the world of the working class.

Here medical science is developed, patients are studied, clinical experiments are carried out and new surgical methods are approved. However, on the opposite side of the street, the fruits of such work are awaited.

> The hospital is the site of a tacit agreement; the bourgeoisie accepts to take care of the poor and they offer their bodies and lives to be used in therapeutic experiments and observation and treatment methods of which the rich will again take advantage. (25 p.7)

The clinical doctor is the watchful scribe of this tacit agreement and the scrupulous executor of such a legacy. The clinical doctor, believing himself the master, serves his true master twice: first, when he bows before the capitalist class and increases his power over the working class; second, when he knowingly or unknowingly imposes the major and unwavering demand of the system: to turn man into a thing, turn his health into a commodity, and turn his life into a usable good for the production of the goods of consumption.

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Turn man into a thing, objectify him: I believe that this is the accepted and implemented task of capitalist medicine, the type of medicine that has allowed you to be the president of the College of Medicine of the province and city of Milan.

He was a laborer, he was 32 years old, and he had a wife and two children. He was also a voluntary and properly registered blood donor. An August morning he received a phone call while he was coming back from the factory night shift. He went where he was told, donated 300cc of blood, came back home and died before dawn. He died of a heart attack after a day of suffering. But, was it a misfortune that could have been avoided? That man had a heart defect: a mitral stenosis originated in another time and place. It is enough to put an ear to the chest to make the diagnosis, but the doctors of the clinic where the worker donated his blood had not even paid him a visit (g).

Now I will keep a distance from our story – because it should not be tarnished – and from all the emotions caused by the misfortune of that man and his family. I also refrain from giving an overall opinion about the transfusion service or about the employees because it is irrelevant. I will only say that this worker is dead because capital and its medicine have used him as an object. It was wrong for him not to have understood that, it was wrong of him to trust, it was wrong of him to be altruistic: the authentic manifestation of the desire to reaffirm one's humanity.

However the reification process was too advanced, even for somebody as young as he, initiated many years ago in the factory where "machinery is put to a wrong use, with the object of transforming the workman…into a part of a detail-machine" (26 p.466); and it continued until his last day with the investment of the natural time of the human being "due to the demand for implants." This process was confirmed by a medicine that had cured him of rheumatic endocarditis without making him understand the consequences; and finally it concluded at a "blood bank" in which he was treated like a thing. A thing provided upon request, containing nearly five liters of Rh-negative type AB, always fresh for possible needs.

This case is extreme and enlightening. This is what we call "an example" because there is a rule underlying it. This is the ironclad rule of the capital and I will set it out: man is not a thing necessary to produce other things. Workers are true men in one dimension: the dimension of the workforce that they can offer and reproduce. Outside this dimension they have no name, citizenship or existence.

Thus, if man is out of the system because of an illness, the system must take interest in him and should make one of three decisions regarding him: exclusion, denial or healing. There is no room for a fourth decision and those three should be carefully assessed and duly enforced: it is better to trust a secular arm of proven competence and submission, capitalist medicine, at the time of choosing the undertaking of the case of individual assistance. The first concern is to silence "everything that, within the disease, despite the smokescreen of medicine, protests against the social order and then, in awareness of it, threatens that order" (25 p.3).

Only someone who has not read one of the most important books of the postwar period (27) does not know that the most efficient way to achieve these purposes is the medical *exclusion* that in psychiatric hospitals, hospices and other places hides the scandal of disease and ratifies the patient as a man as well as a thing necessary for obtaining other things. As he loses all credit as a workforce provider and as an orderable element of a productive machine, he will be led to that extreme reification that will not only cause the loss of his own identity but also the uncertainty of his place in the world.

Denial, Mr. President, is subtler but certainly more used by the current medical practice as a first method to manage the patient's suffering, which should in itself constitute enough proof of the patient's authenticity for the investigation of his symptoms. By denying some diseases and silencing others, the worker who remains ill is offered the option of being healthy or unjustifiably unproductive. Naturally, capitalist medicine is helped by science to carry out an operation like this one, because it has to confirm the "existence" of a disease around which the entire medical education provided at the university revolves. If the disease "exists," the ill person is one who has been battered by one or more diseases and the healthy person is defined negatively as the person who is disease-free. If, then, it can be objectifiable in terms of its existence, it only exists in

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terms of being objectifiable. The not uninterested observation of these conditions will be enough to accept the dieresis between symptom and disease, pain and damage, suffering and misery, in which the womb of an alienated medicine gives birth to the figure of a diseased man without disease, a man reinstated in his work duties and the silence of his protest. It is stated that healthy people are those who are not ill, and there are a number of diseased people who do not know that they are healthy, and although it is true that people who are ill are not healthy, and it is also true that there are a certain number of healthy people who do not know that they are ill (28 p.259).

But the traditional distinction between the "functional" and "organic" patient (29) helps restrict immediately the credibility of suffering, which is denied and rejected when there is insufficient evidence of the injuries. The "functional" patient – for example, the worker who bears the exploitation of physical and mental energy produced by the fatigue and harm, the time and pace, the repetition and confinement, the tension and monotony of inhuman work – bears all the burden of proof: to learn to be an "organic" patient!

On this basis, Mr. President, capital was allowed to say, with the authoritative voice of scientific medicine, that the unequal distribution of diseases in the social classes, supported by an impressive quantity of hardly remembered conclusive information, should not be understood in terms of *disease* but in terms of *discomfort*. In fact, the working class will not *know* it, but will *feel* unhealthier than the capitalist class (30 p.67). So much so that the working class precedes the other on the way to the cemetery.

In order to distract the working class from such a naïve mistake, capitalist medicine has invented one last trick: a prophetic medicine disguised as preventive medicine. Early diagnosis, check-ups, laboratory screenings, multifarious tests – so widely advertised by the joint *battage* of medicine and industry that they even reach the working class – are completely useless and inadequate to look after health (31 p.1). Capitalist medicine does no more than assume, within the alleged and unfulfilled search for disease, the negation of the existence of disease at a higher level of rationalization and administration. Its real function is to serve as social tranquilizer by using a diseased person suffering from a truly "organic disease" (cancer, diabetes, or others, whose fate will unfortunately remain unaltered) as a *dépistage* so as to give others a necessary false security in order to extend their possible exploitation over the course of time.

The true preventive medicine, Mr. President, the only one that makes any sense, is not the one proposed by capital, but that one which is opposed by capital. This is the type of medicine that seeks to find the pathogenic causes and eliminate them instead of looking at the effects and disguising them under the artifice of an early diagnosis. However, if the causes lie in the production process, in social administration, in the stressful lifestyle imposed by capital, it means that capital is – and undoubtedly it is – a pathogen itself. Will medicine be able to fight against capital to the benefit of man, that very medicine that is the mediator of capital's power over men?

Furthermore, I have admitted that this medicine does not restrict itself to excluding or negating the diseased person; sometimes it does cure the patient, sits by his bed and is finally "on his side." But this is not so, Mr. President. When I deny this, I do not want to raise doubts about the subjective certainty that the doctor, taken in an isolated way, may have of his philanthropic role, played with dedication and rewarded by the recognition his performance receives. I refer to something else entirely. For capitalist medicine, *the management of the medical assistance* provided to the worker aims at preserving the identity assigned to him by the production system.

When "a thing" does not work properly, it must be repaired and its functions restored. This is obvious. What is most important but less obvious is that that the "thing" not become a man again; if he does he may not be able to be reintegrated, even though he has been prepared for that purpose. Consequently, he must be kept in his state, under close and constant surveillance during the entire health process, so as to avoid that the "thing" become aware of his situation, that the disease become an accusation for which capital is responsible.

Curing will mean, in terms of the diagnosis, reducing the patient to his illness, the illness to its organic location, the diseased organ to an objectifiable damage, the damage to a mark and the

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mark to a measurement. Afterwards, from the therapeutic perspective, the opposite path should be taken: the healed mark disguised as the elimination of damage, the silence of the organ as the defeat of illness, the absence of illness as the restoration of health.

In this process that is repeated every day in clinics and hospitals, the objectified man becomes another person's thing: a master or a doctor, it makes no difference if the doctor's science is that of the master too.

Under their commands, the doctor manages the patient in a close and interindividual relationship in which, as expected, Mr. President, the Colleges of Medicine emphatically defend the private attribute. A relationship of this kind ratifies the patient's certainty of solitude, the objective mandate under which he is renewed and reaffirmed.

In this solitude, where his personal history is lost in his clinical record, his subjectivity may be rejected by medical tests and even his individuality is depersonalized during the disease, he is taught to live as a "case," that is, to alienate himself as a "thing."

He is alone with his fear and his hope, his pain and his "recovery." He feels lonelier the more in appearance he is cared for; in fact he is being used, so that he is unable to realize that his illness is actually his personal history; and that this history does not belong to things but to men; and that men's history is based on class struggle and that only with the victory of his class will he and his fellow men be able to be safe and healthy.

Consequently, this is the logical core of the capitalist management of the diseased (h); it will coordinate all its stages ranging from drugs, the hospital, the laboratory, the mutual organizations and so on, through a map of clear but exorbitant text, upon which this series will be focused, upon the volumes that you will not read, Mr. President.

What is more, that another doctor read these lines and pages is my strongest wish; that they may help him acknowledge the danger of his situation, reject his sentence and face his crisis.

Wherever his workplace is – a university clinic, a provincial hospital, a working class neighborhood or a rural environment – capitalist medicine will reach him because it needs him. The capitalist mandate, which has constrained science and medicine, patients and diseases, which has reduced man to the prison of alienation, demands that the doctor become the vigilant guardian of this prison (32).

As a result, he has learned to exclude, negate and manage other men, since this is the hypothesis carried out in every prison.

> What is fascinating about prisons is that, for once, power doesn't hide or mask itself; it reveals itself as tyranny pursued into the tiniest details; it is cynical and at the same time pure and entirely "justified," because its practice can be totally formulated within the framework of morality. Its brutal tyranny consequently appears as the serene domination of Good over Evil, of order over disorder (33 p.69).

This should be the view of someone who, although aware of that power, is at the same time trampled under its foot: the doctor, of course.

He receives the advantage and power, the authority and the knowledge. Fooled by the myths about the "mission" and professional "freedom," he is allowed to dictate the clauses, set the codes ruling the doctor-patient relationship. Indeed, his are the language and the discourse, the place and the time, the rules and the freedom. Above all, thanks to him, the subjectivity of an act that he must perform and affirm upon an objectified man is humored.

This only happens because – once his doubt is dispelled by false conscience and his scruples anesthetized by profits – he does not realize that he is in fact a managed manager.

He must not notice that his will to cure the patient is destroyed as soon he returns the patient to the cause of his disease; that his desire to prevent the disease reaches its end with the anticipation of a suffering that will continue to exist; and that his purpose to alleviate suffering is extinguished when he calms the worker's protest.

Therefore, he is as much in crisis as the patient with whom he shares the sentence and salvation. The doctor's only salvation lies in the patient who asks to be saved.

He will be able to save the patient when he learns to truly assume his patient's defense, when he learns to fight with and for the patient's rights regarding his health and his life, when he learns to create a science tailored to the patient and a

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medicine at the service of the patient, when he learns to support the exploited classes in a fight against the leading classes and work against capital.

Capitalist medicine will cease to exist when the doctors understand the deep politicization and the liberating potential of their work.

And along with it will cease to exist Colleges of Medicine like this one, presidents like you, and the memory of both.

Mr. President, the inquisition also saw greatness and the inquisitors could also wear the trappings of majesty. But you have not reminded me of them.

The poor sustenance and little flourish of your statements (i) highlights – on behalf of a Center for the Defense of Doctor Dignity – your health-based reinvention of the *officium inquisitioni shaereticae pavitatis*, includes some *edicts of faith* (but not edicts of grace), refers us to some *acts of faith* and unsuccessfully attempts a *sermo generalis*. But they do not have a trace nor a memory nor even a hint of Bernardo da Guido's inquisitive theory, of the accusatory lucidity of Raimondo da Piñafont, of the bright and terrible severity of Juan Ruiz de Mendoza.

Oh, Mr. President, I must bid you farewell, but I am concerned. When after a naïve inquiry on my part, you answered that you were certain of my heresy because I formulated it in the classroom in Perugia where you were lecturing, I felt pity. Not so much for your valor, which faltered on that occasion faced with the epiphany of your presence and thoughts – that were absolutely silent and ignorant of the chronicles of the convention – but for my fear, which turned into a certainty, that you only knew the temptations and vices of inquisition, but not the standards and procedures. However, I know that the persecution of the *separantes se a comunitate aliorum* is not only different from the *haeretici, qui in suo errore perdurant* (among whom you include me) and then from *celatores, occultatores, receptores, defensores, fautores et relapsi* but also from *suspecti* (who innocently declare themselves) because they are guilty of having listened to a heretic speech without any expression of disagreement and any invocation to exorcism.

How is it that I opened this letter in the same way I am closing it now? I do not think, Mr. President of the College of Medicine of the Province and City of Milan, that the speech communicated in these pages may be considered heretic, although you may have understood it to be from your slanted point of view. Because in fact, the *communitate aliorum* separates you, and not me, from that community of peers, colleagues and students that even here – in a fully different way from the transparent irrelevance that is so typically yours – I have addressed convincingly.

Milan, October 1972

END NOTES

a. We found a good description of the facts in Aaron Antonovsky's Social class, life expectancy and overall mortality (1).

b. "This may be illustrated by recalling what happened when an 'unsinkable' trans-Atlantic luxury liner, the Titanic, rammed an iceberg on her maiden voyage in 1912. In that crisis, a passenger's class status played a part in the determination of whether he survived or was drowned. The official casualty list showed that only 4 first class female passengers (3 voluntarily chose to stay on the ship) of a total of 143 were lost. Among the second class passengers, 15 of 93 females drowned; and among the third class, 81 of 179 female passengers went down with the ship. The third class passengers were ordered to remain below deck, some kept there at the point of a gun" (2 p.107) cited by Hollingshead and Redlich (3 p.12).

c. For example, in the literary field alone, E. Zola's debt to C. Bernard is just one of the few recognized among the several debts incurred.

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d. The Il Giorno from April 10th, 1969 states on page 4 that the President of the INAIL declared to the agency Italia that the phenomenon (one and a half million cases in a year, one death per every working hour, an injured person every six seconds) takes on the dimensions of a war.

e. Personal communication with H. Terzian.

f. If you are not convinced (and even if you are) read one of the best books of 1972 (21).

g. This story is historically accurate: names and data are omitted because the Prosecutor's Office of the Republic of Lodi (Milan) is investigating the case.

h. Consult the first two fascinating chapters by M. Gaglio (16).

i. Consult the Bolletino Ordine dei Medici Milano e Provincia, via Lanzone 31, Milan.

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